IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JOHN M. PERGOSKY,	:	CIVIL ACTION
	:	
	:	
v.	:	
	:	
LIFE INSURANCE COMPANY OF NORTH AMERICA and CIGNA INSURANCE COMPANY	:	
	:	
	:	NO. 01-4059

MEMORANDUM

Padova, J. **March 24, 2003**

The instant action arises on Defendants' Life Insurance Company of North America and CIGNA Insurance Company's Motion for Summary Judgment and Plaintiff John M. Pergosky's counter-motion for "Judgment as a Matter of Law Based Upon Stipulated Facts." For the reasons that follow, the Court grants Defendants' Motion. Plaintiff's Motion is denied.

I. Procedural Background

Plaintiff John M. Pergosky originally filed the instant suit in the Court of Common Pleas, Lehigh County. Plaintiff alleges that Defendants Life Insurance Company of North America ("LINA") and CIGNA Insurance Company ("CIGNA") breached their insurance contract with him by denying him benefits under a conversion policy ("Conversion Policy") for long-term disability insurance. Defendants removed the case to federal court on the basis that it is covered by the Employment Retirement Income Security Act of 1974

("ERISA"), 29 U.S.C. § 1001, et seq., and on the basis of diversity jurisdiction. Plaintiff moved to remand the case. On October 25, 2001, the Court denied Plaintiff's Motion to Remand based on diversity grounds, and did not reach the ERISA issue. On December 3, 2001, the Court denied Plaintiff's "Motion for Reconsideration of Order of October 25, 2001." Defendants move for summary judgment primarily on the basis that the subject policy is governed by ERISA and, under the terms of the ERISA Plan, benefits are not available because Plaintiff, who was already disabled, was ineligible for conversion disability insurance coverage. Plaintiff contends that ERISA does not apply and has filed a counter-motion. The Court held a hearing on the Motions on March 18, 2003. For the reasons that follow, the Court grants Defendants' Motion and denies Plaintiff's Motion is all respects.

II. Factual Background[1]

Plaintiff was employed at Pennsylvania Power & Light Company ("PP&L"). PP&L sponsors, endorses and maintains an employee disability benefit plan (the "Plan") for its employees. Prior to 1992, LINA issued Policy No. LK-7635-001 ("Group Plan Policy") to PP&L so as to underwrite Plan benefits. As a PP&L employee, Plaintiff participated in the Plan. Plaintiff had been employed as a construction supervisor at PP&L for a number of years prior to

[1]The parties submitted a stipulation of facts to the Court. See, e.g., Defs.' Mot., Ex. A. The Court's recital of the factual background is based on the parties' submission.

August 17, 1992. Plaintiff will turn 65 years old on May 26, 2003.

Plaintiff started suffering from severe migraines in 1989 or 1990, necessitating medication. As a result, from 1989 to August, 1992, Plaintiff missed work at PP&L. On June 11, 1992, Plaintiff's treating physician recommended that he take a medical leave of absence from his job. On June 22, 1992, Plaintiff took leave from his employment with PP&L, which PP&L classified as sick leave. On August 17, 1992, while still on sick leave, PP&L terminated Plaintiff from his employment for reasons unrelated to his medical leave. Plaintiff has not been employed since his 1992 termination at PP&L.

On September 24, 1992, PP&L provided to Plaintiff a Notice of Conversion Privilege for long-term disability insurance (the "Conversion Notice") (Defs.'s Mot., Ex. 3.) The Conversion Notice included three documents: (1) a short description of the converted disability benefit; (2) an application for conversion of group long-term disability insurance to be completed by the employee; and (3) an employer certification of the employee's eligibility. Among other things, the CIGNA conversion notice set forth instructions to individuals, stating in part "[Y]ou are eligible if you have been insured at least 12 months under your employer's plan and you resign, are laid off or take a non-disability leave of absence. You are not eligible if you retire, are age 70 or more, are disabled, or if your employer's policy is terminated." (Defs.' Mot., Ex. 3)

(emphasis added). Plaintiff elected to convert the group Plan into an individual plan and filled out the Application for Conversion on September 28, 1992, and tendered the initial deposit.

The employer, acting through Mary Charnaski, filled out the employer certification of eligibility, which stated that Plaintiff was not disabled under the terms of the PP&L Long Term Disability Plan at the time of his August 17, 1992 termination and that Plaintiff was not receiving any disability income from the Plan. CIGNA accepted Plaintiff's application to convert his coverage under the Plan Policy to an individual policy ("Conversion Policy") in reliance on the representation by PP&L that Plaintiff was not disabled. The Conversion Policy was identified by CIGNA to be GKC 0600000. CIGNA never sent Plaintiff a copy of the Conversion Policy.

The PP&L group disability Plan provides for a 180-day waiting period before a claim can be filed. The waiting period for Plaintiff's claim expired on December 19, 1992. On December 21, 1992, Plaintiff submitted a claim under the individual disability policy identified as GKC 0600000, which was received in Dallas on January 20, 1993, containing a date of disability as of June 22, 1992.

On March 23, 1993, CIGNA employee Lila Langdon wrote to CIGNA employee Jana Bezdek raising questions as to which policy covered Plaintiff's claim, the group Plan or the Conversion Policy. On

April 1, 1993, LINA notified Plaintiff of its decision that the claim should be made under the Group policy at LK-7635,[2] and not under the Conversion Policy due to the date of disability of June 22, 1992. On May 21, 1992, LINA employee Jana Bezdek wrote to LINA employee Javon Johnson that Mr. Pergosky's claim was being filed with the group carrier and that LINA should refund his premium. LINA failed to do so at the time.

Instead, from the date of the conversion, LINA sent Plaintiff a quarterly bill, which Plaintiff timely paid. Plaintiff applied for and received Social Security disability benefits in 1993 based on his severe migraines. On October 22, 1993, CIGNA advised Plaintiff that his long-term disability claim under the PP&L group Plan had been approved. LINA paid Plaintiff accrued benefits for the period of January 24, 1993 through October 23, 1993, and has continued to pay him through the present the benefits due him under the Plan for his 1992 total disability.

In July 1999, Plaintiff suffered a stroke. Prior to this stroke, Plaintiff continued to suffer severe migraines. On November 15, 1999, Plaintiff received claim forms for the individual converted policy GKC 301012. On or about November 26, 1999, Plaintiff submitted an application for benefits under the

[2]The Court notes that there are discrepancies in the policy numbers listed in the Stipulated Facts and when compared to those numbers listed on the jointly submitted exhibits of the policies. The Court assumes that these discrepancies are typos. These discrepancies, however, are irrelevant to the Court's analysis.

Conversion Policy because of his stroke, and subsequently submitted medical evidence that he was disabled from any occupation. On February 17, 2000, Defendants denied Plaintiff disability benefits under the Conversion Policy. Plaintiff filed this present action on August 3, 2001. After litigation commenced, LINA tendered the Conversion Policy premiums to Plaintiff, which Plaintiff returned to LINA.

III. Legal Standard

Summary Judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c) ("Rule 56"). An issue is "genuine" if the evidence is such that a reasonable jury could return a verdict for the non-moving party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). A factual dispute is "material" if it might affect the outcome of the case under governing law. Id.

A party seeking summary judgment always bears the initial responsibility for informing the district court of the basis for its motion and identifying those portions of the record that it believes demonstrate the absence of a genuine issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). Where the non-moving party bears the burden of proof on a particular issue at

trial, the movant's initial Celotex burden can be met simply by "pointing out to the district court that there is an absence of evidence to support the non-moving party's case." Id. at 325. After the moving party has met its initial burden, "the adverse party's response, by affidavits or otherwise as provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). That is, summary judgment is appropriate if the non-moving party fails to rebut by making a factual showing "sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex, 477 U.S. at 322. Under Rule 56, the Court must view the evidence presented on the motion in the light most favorable to the opposing party. Anderson, 477 U.S. at 255. "If the opponent [of summary judgment] has exceeded the 'mere scintilla' [of evidence] threshold and has offered a genuine issue of material fact, then the court cannot credit the movant's version of events against the opponent, even if the quantity of the movant's evidence far outweighs that of its opponent. Big Apple BMW, Inc. v. BMW of North America, Inc., 974 F.2d 1358, 1363 (3d Cir. 1992).

Where, as here, cross-motions for summary judgment have been presented,[3] the Court must consider each party's motion

[3]Though Plaintiff's Motion is entitled "Judgment as a Matter of Law Based Upon Stipulated Facts," the Court treats the Motion as a cross Motion for Summary Judgment. In Plaintiff's proposed order,

individually. Each side bears the burden of establishing a lack of genuine issues of material fact. Reinert v. Giorgio Foods, Inc., 15 F. Supp. 2d 589, 593-94 (E.D. Pa. 1998).

IV. Discussion

Defendants mainly argue that Plaintiff's claim arises under ERISA because it relates to the right to convert the group long-term disability Plan to an individual conversion plan. They further argue that pursuant to ERISA, LINA reasonably denied Plaintiff benefits. Plaintiff contends that this is not an ERISA case and that he does not seek to enforce a right to convert a group policy into an individual policy because the conversion happened ten years ago and Defendants have collected premiums thereafter, but that he seeks to enforce benefits due under the Conversion Policy. Plaintiff also contends that even if the Court determines that this action is governed by ERISA, he is entitled to benefits under the appropriate standard of review for a denial of benefits under an ERISA plan, and/or under the doctrine of waiver.

A. Applicability of ERISA

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he states "upon consideration of cross-motions for judgment as a matter of law" but Defendants filed a Motion for Summary Judgment, the more common nomenclature for these motions. Moreover, aside from the title of his Motion, Plaintiff never states under which Federal Rule of Civil Procedure his files his Motion and never provides any legal standard by which the Motion is to be adjudicated. The standard for a summary judgment motion states when a party is entitled "to judgment as a matter of law." Fed. R. Civ. P. 56(c). Accordingly, both Motions are treated as Motions for Summary Judgment.

Under ERISA, "[a] civil action may be brought – (1) by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of his plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C.A. § 1132(a)(1)(B)(West 2001). A "participant" is:

> any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29.U.S.C.A. § 1002(7) (West 2001). As a former employee, Plaintiff is considered a participant under Section 1002(7).

The Court must determine whether Plaintiff's claim relates to a plan that falls within the definition of an "employee benefit plan" covered by ERISA. "'The existence of an ERISA plan is a question of fact, to be answered in light of all the surrounding circumstances from the point of view of a reasonable person.'" Zimnoch v. ITT Hartford, No.99-6594, 2000 U.S. Dist. LEXIS 2846, at *10 (March 16, 2000) (quoting Zavora v. Paul Revere Life Ins. Co., 145 F.3d 1118, 1120 (9th Cir. 1998)). ERISA defines an "employee welfare benefit plan" as:

> any plan, fund, or program which has heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or

> is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability . . . .

29 U.S.C.A. § 1002(1). See also Martin v. Continental Cas. Co., No.99-CV-5574, 2000 U.S. Dist. LEXIS 2334, at *5 (E.D. Pa. Feb. 28, 2000).

In evaluating whether ERISA applies in actions arising based on conversion insurance policies, the courts determine whether the claims relate to rights to conversion or to benefits under a conversion policy. Almost all of the courts that have addressed the issue have agreed that rights to conversion are governed by ERISA because they stem from the group plan, an ERISA plan. There is a split among circuit courts and several district courts as to whether benefits under a conversion policy are governed by ERISA. See, e.g., Waks v. Empire Blue Cross/Blue Shield, 263 F.3d 872 (9th Cir. 2001) (conversion benefits are not governed by ERISA); DeMars v. Cigna Corp., 173 F.3d 443 (1st Cir. 1999)(same); Barringer-Willis v. Healthsource North Carolina Inc., 14 F. Supp. 2d 780, 783 (E.D. N.C. 1998)(same); McCale v. Union Labor Life Ins. Co., 881 F. Supp. 233 (S.D.W.V. 1995)(same); Mimbs v. Commercial Life Ins. Co., 818 F. Supp. 1556, 1562 (S.D. GA. 1993)(same); Glass v. United of Omaha Life Ins. Co., 33 F.3d 1341 (11th Cir. 1994) (holding that conversion benefits are governed by ERISA); Painter v. Golden Rule Ins. Co., 121 F.3d 436 (8th Cir. 1997) (same); Nechero v. Provident

Life & Accident Ins. Co., 795 F. Supp. 374, 380 (D.N.M. 1992) (same). The Court need not decide whether ERISA benefits under a conversion policy are governed by ERISA, however, because it determines that Plaintiff's claims relate to conversion rights, not conversion benefits.

In White v. Provident Life & Accident Ins., 114 F.3d 26, 28 (4th Cir. 1997), the United States Court of Appeals for the Fourth Circuit held that the plaintiff's claims under a conversion policy (he also had a group policy) were clearly related to the conditions placed by the group policy on the right of conversion, and, therefore, his claims were governed by ERISA. In White, the Plaintiff had a group insurance plan whose terms prohibited an insured from being simultaneously covered by both group and individual coverage. Id. at 27. The insurance company mistakenly issued Plaintiff an individual conversion policy. Id. The plaintiff tendered premiums for the conversion policy from the time the policy was issued in 1984 until the summer of 1988, at which point the insurance company discovered it had erroneously issued a conversion policy to the plaintiff. Id. Immediately after this discovery, the insurance company notified the plaintiff that he could not maintain simultaneous coverage under both policies and repaid all premiums previously paid under the individual conversion policy. Id. The plaintiff refused to accept the repayment and refused to return the individual policy. In reaching its holding,

the court reasoned:

> It is clear that under this ERISA plan, a beneficiary may claim coverage under either the group policy or a conversion policy, but not both. The group policy states: If a converted policy is issued under the plan, it must be returned without claim before insurance will be continued under the group policy. Any premiums paid for the converted policy will be returned to you.

Id. at 28. The policy also stated "nothing will be paid under the [conversion policy] if any amount is paid under the [group policy]." Id. The Court further reasoned:

> The group policy thus allows an insured to obtain individual conversion coverage as an alternative, but not in addition to, group coverage. The written terms of this ERISA plan plainly prohibit simultaneous recovery under the group policy and a conversion policy, and ERISA demands adherence to the clear language of this employee benefit plan.

Id.

Likewise, Plaintiff's claim for benefits is related to conditions placed by the group Plan on the right of conversion, and thus is governed by ERISA. The "Notice of Conversion Privilege" sent by CIGNA to Plaintiff states: "You are not eligible if you . . . are disabled . . . ." (Defs.' Mot., Ex. 3 at 3.) The "Notice of Conversion Privilege" stems from the group Plan, an ERISA plan, and relates to the right to convert. It clearly states: "You are not eligible if you . . . are disabled . . . ."[4] (Defs.' Mem. Ex. 3 at

[4]The Court notes that the group Plan itself reads in pertinent part: "An employee is not Entitled to Convert if: (4) he is not in

3.) Furthermore, in his Motion, Plaintiff concedes that "[t]he parties agree that [he] should not have been entitled to purchase and pay for an Individual Conversion Plan . . . ." (Pl.'s Mot. at 1.) He states that it is "undisputed that [he] should not have ended up with both policies [group and individual conversion]" and cites to Stipulated Fact number 20 which recites the relevant provision in the Notice of Conversion Privilege: "[Y]ou are not eligible if you retire, are age 70 or more, are disabled . . . ." (Pl.'s Mem. at 2.) Accordingly, the Court finds that Plaintiff's claim relates to conversion rights, as it "relate[s] to the conditions placed by the group policy on the right of conversion," and therefore is governed by ERISA. White, 114 F.3d at 28.

B. Applicability of Waiver

Plaintiff argues that waiver is applicable. "Waiver is 'the voluntary, intentional relinquishment of a known right.'" Variety Children's Hosp., Inc v. Miami Children's Hosp., 942 F. Supp. 562, 570 (S.D. Fl. 1996) (citing Glass v. United Omaha of Life Ins. Co., 33 F.3d 1341, 1347 (11th Cir. 1994)). Few courts have held that waiver is generally part of the common law of ERISA, but instead have performed case-specific waiver analyses. See, e.g., Russo v.

Active Service because of disability." (Defs. Mot., Ex. 1 at 6a.) Here, Plaintiff was "not in active service" due to termination from his employment position, not due to disability. Notwithstanding, the Court concludes that the right to convert, as evinced in the Notice of Conversion Privilege, stems from the group Plan and specifically excludes an already disabled person from receiving conversion coverage.

Abington Mem. Hosp., Civil Action No. 94-195, 2002 U.S. Dist. LEXIS 15493, at *39 (E.D. Pa. Aug. 1, 2002); Lauder v. First UNUM Life Ins. Co., 284 F.3d 375 (2d Cir. 2002); Juliano v. Health Maintenance Organization of New Jersey, Inc., 221 F.3d 279, (2d Cir. 2000); Glass v. United of Omaha Life Ins. Co., 33 F.3d 1341, 1348 (11th Cir. 1994). In doing so, the majority of courts that have examined the issue have held or noted that waiver is unavailable when it would expand the scope of coverage under an ERISA plan. See Russo, U.S. Dist. LEXIS 15493, at *39; Lauder, 284 F.3d at 381; cf. Juliano, 221 F.3d at 288.

For example, In Lauder, the United States Court of Appeals for the Second Circuit ("Second Circuit") found waiver when the insurer failed to raise a lack of disability as a defense. Id. at 382. The court reasoned that "waiver here would not create coverage where none would otherwise exist; rather, [plaintiff's] disability is exactly the type contemplated by the policy." Id. at 382. In Juliano, the Second Circuit held that the defense of medical necessity had not been waived by the defendant because medical necessity was a required element for coverage and thus could not be waived. 221 F.3d 279. The court reasoned that "[e]ven when insurance coverage is denied, 'where the issue is the existence or nonexistence of coverage (e.g. the insuring clause and exclusions), the doctrine of waiver is simply inapplicable.'" Id. But see Pitts

v. American Sec. Life Ins. Co., 931 F.2d 351, (5th Cir. 1991).[5]

The Court follows the reasoning in Lauder and Juliano and denies waiver in this instant action. Applying waiver would expand coverage beyond the provisions of the ERISA group Plan. The ERISA group Plan clearly states that an applicant with a disability is ineligible for conversion coverage. In this case, despite Defendants' mistake and continued receipt of Plaintiff's premiums for more than ten years, waiver is not available because it would rewrite the Plan to include covering an already disabled participant, something it clearly excludes. Accordingly, the Court finds waiver inapplicable and limits this holding to the

[5]In Pitts v. American Sec. Life Ins. Co., 931 F.2d 351, (5th Cir. 1991), the United States Court of Appeals for the Fifth Circuit found that waiver had occurred when the defendant accepted premiums from the employer for five months after learning that the Plaintiff was the only employee remaining on the policy, a breach of the policy requirements. The defendant later cashed these premium checks to recoup some of its losses on the policy. The court found that the defendant waived its right to assert a defense to its liability under the policy because, after it learned that the policy requirements had been breached, it could have protected any possible right to deny liability by executing an ordinary reservation of rights. Instead, it accepted premium payments and paid medical benefits without reservation. Id.

In Matinchek v. John Alden Life Ins. Co., 93 F.3d 96, 103 (3d Cir. 1996), a non-ERISA case, the Third Circuit commented about waiver and cited to the ERISA case of Pitts: "It is certainly true that in some instances a waiver finding would be appropriate where the insurer continues to accept premiums after it has investigated and determined that it has the right to rescind." Id. at 103 (citing Pitts). Notwithstanding, the Court follows the line of cases holding waiver inapplicable when it expands the scope of coverage, as it would here, "where the issue is the existence or nonexistence of coverage (e.g. the insuring clause and exclusions)." Juliano, 221 F.3d at 288.

circumstances of this particular claim.

C. Preemption

The Court must examine whether Plaintiff's claim is preempted because his sole count alleges breach of contract, not any ERISA violation. The Court concludes that Plaintiff's claim is completely preempted by ERISA and, therefore, federal in nature, giving the Court jurisdiction to review the claim for denial of benefits. Complete preemption operates to confer original federal subject matter jurisdiction notwithstanding the absence of a federal cause of action on the face of the complaint. In re U.S. Healthcare, Inc., 193 F.3d 151, 160 (3d Cir. 1999). "State-law claims that are subject to express preemption are displaced and thus subject to dismissal. Claims that are completely preempted are 'necessarily federal in character,' and thus are converted into federal claims." Id. (citations omitted). In determining whether Plaintiff's claim is completely preempted, the Court considers whether it "'falls within the scope of' ERISA's civil-enforcement provisions." Id. (citation omitted). "Under section 502(a)(1)(B), a participant or beneficiary may bring an action 'to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.'" Id. (citing 29 U.S.C. § 1132(a)(1)(B)). "Claims 'that the plans erroneously withheld benefits due' or that seek 'to enforce [plaintiff's] rights under their respective plans or to

clarify their rights under their respective plans or to clarify their rights to future benefits,' [a]re subject to complete preemption." Id. at 161-62 (citation omitted). Plaintiff's claim for denial of long-term disability benefits under the Conversion Policy falls within the scope of ERISA's civil-enforcement provisions. Id. at 161 (citation omitted)(noting that rights under the terms of the plan apply to such matters as benefit eligibility procedures). Accordingly, the Court exercises jurisdiction over Plaintiff's claim and reviews Defendants' denial of benefits.

D. Review of Denial of ERISA benefits

A denial of benefits under ERISA is ordinarily reviewed under a de novo standard. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989). "ERISA mandates that [the reviewing court] apply a deferential 'arbitrary and capricious' standard of review to benefits decisions when plan administrators are given discretionary authority to interpret the terms of the plan." Reinhart v. Giorgio Foods, Inc., 15 F. Supp. 2d 589, 596 (E.D. Pa. 1998) (citing Abnathya v. Hoffman-LaRoche, Inc., 2 F.3d 40, 44-45 (3d Cir. 1993)); see also Firestone Tire & Rubber Co., 489 U.S. at 109. Here, Defendants argue that LINA was conveyed discretion in claim determinations. (Defs.' Mem. at 10.) Where an insurance company both determines eligibility for benefits and pays benefits out of its own funds, the standard of review is "heightened" arbitrary and capricious review. Pinto v. Reliance Std. Life Ins. Co., 214 F.3d

377, 378 (3d Cir. 2000). Under this "heightened" approach, the courts apply a "sliding scale" approach that integrates the conflict as a factor in applying the arbitrary and capricious standard. Pinto, 214 F.3d at 393. Courts must consider the nature and degree of apparent conflicts with a view to shaping their arbitrary and capricious review of the benefits determinations of discretionary decision makers. Id. Factors a court may take into account in determining the appropriate degree of deference include: "the sophistication of the parties, the information accessible to the parties, . . . the exact financial arrangement between the insurer and the company [and] the current status of the fiduciary." Id. at 392. The degree of review increases in proportion to the intensity of the conflict. Friess v. Reliance Standard Life Ins. Co., 122 F. Supp. 2d 566, 572 (E.D. Pa. 2000). Evidence of significant conflict of interest places a case at the far end of the sliding scale, under which the court reviews the administrator's decision with a "high degree of skepticism." Pinto, 214 F.3d at 395.

> Under the heightened standard, a plan administrator's decision will be overturned only if it clearly is not supported by the evidence in the record or the administrator has failed to comply with the procedures required by the plan. A court is not free to substitute its own judgment for that of the defendants in determining eligibility for plan benefits.

Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc., 298 F.3d 191,

199 (3d Cir. 2002) (citation omitted). "'Whether a claim decision is arbitrary and capricious requires a determination whether there was a reasonable basis for [the administrator's] decision, based upon the facts as known to the administrator at the time the decision was made.'" Id. at 199-200(citation omitted). Here, the Court will automatically apply the heightened standard of review at the farthest end of the sliding scale, "the high degree of skepticism," without determining whether it is necessary, because, even under this highest standard, Plaintiff's claim fails.

The Court determines that the terms in the ERISA group Plan regarding eligibility for coverage are not ambiguous. A term is 'ambiguous if it is subject to reasonable alternative interpretations.'" Id. at 2000. "In determining whether a particular clause in a plan document is ambiguous, courts must first look to the plain language of the document." Id. (citing In re UNISYS Corp. Retiree Med. Benefit 'ERISA" Litig., 58 F.3d 896, 902 (3d Cir. 1995) ("The written terms of the plan documents control . . . . ")). "[The Court] must first determine the legally correct interpretation of the disputed plan provision. If the administrator's interpretation was legally correct, the inquiry ends. If the administrator's interpretation differs, we must then determine whether the administrator was arbitrary and capricious in employing a different interpretation." Hird v. Bostrom Seating, Inc. 147 F. Supp. 2d 1190, 1200 (N.D. Al. 2001) (citing Adams v.

Thiokel Corp., 231 F.3d 837, 842 (11th Cir. 2000)).

The "Notice of Conversion Privilege," which stems from the group Plan states, "You are not eligible if you . . . are . . . disabled . . . . (Defs.' Mot., Ex. 3 at 3.) These unambiguous terms of the Plan clearly exclude disabled participants from being eligible to convert the insurance policy. Accordingly, Defendants decision to deny Plaintiff's claim for benefits, for which Plaintiff was not eligible, was legally correct. The Court therefore finds that Defendants' denial of Plaintiff's benefits was proper. Accordingly, Defendants' Motion for Summary Judgment is granted in its entirety.

E. Inapplicability of an Incontestability Clause

Plaintiff's Motion is primarily based on the argument that the law regarding incontestability clauses prevents Defendants from contesting that Plaintiff is not covered under the conversion policy. First, the Court has not found any incontestability clause in either the group Plan policy or the Conversion Policy. More importantly, the Court concludes that even if such an incontestability clause existed or were deemed to exist, it would not prevent Defendants from invoking the plain terms of the ERISA plan. See White v. Provident Life & Accident Ins. Co., 114 F.3d 26, 28-29 (4th Cir. 1997) ("An incontestability clause prevents an insurer from contesting the validity of an insurance contract. However, such a clause certainly does not prevent the insurer from

invoking the plain terms of an ERISA plan."). In White, the court noted that the issue was not whether the group policy is valid, but rather whether it forbids a double recovery under a group plan and an individual conversion plan, an invocation of the plain terms of the ERISA plan. Id. at 28-29. The court held that the ERISA plan plainly included such a prohibition, and the insurer was entitled to assert it. Id. at 29. Likewise, here, the group Plan, from which the right to convert stems, clearly excludes already disabled persons from eligibility for coverage. Because the ERISA group plan plainly includes such a prohibition for conversion insurance coverage for disabled applicants, Defendants are entitled to assert as such, regardless of whether an incontestability clause exists or should be deemed to exist. Accordingly, Plaintiff's Motion is denied in its entirety.

V. Conclusion

The Court grants Defendants' Motion for Summary Judgment and enters judgment in favor of Defendants and against Plaintiff.[6] Plaintiff's Motion is denied in its entirety.

An appropriate Order follows.

[6]The Court notes that Defendants have acknowledged that they owe Plaintiff the premiums he paid toward the Conversion Policy.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JOHN M. PERGOSKY,	:	CIVIL ACTION
	:	
	:	
v.	:	
	:	
LIFE INSURANCE COMPANY OF NORTH AMERICA and CIGNA INSURANCE COMPANY	:	
	:	
	:	NO. 01-4059

O R D E R

AND NOW, this 24th day of March, 2003, upon consideration of Defendants' Motion for Summary Judgment (Doc. No. 37), Plaintiff's Response thereto and counter Motion "For Judgment as a Matter of Law Based Upon Stipulated Facts" (Doc. No. 36), any and all supporting and opposing briefing thereto, and the hearing held before the Court on March 18, 2003, **IT IS HEREBY ORDERED** that Defendants' Motion (Doc. No. 37) is **GRANTED** and Plaintiff's Motion (Doc. No. 36) is **DENIED**. **JUDGMENT** is entered in favor of Defendants and against Plaintiff. This case shall be closed for statistical purposes.

BY THE COURT:

_____
John R. Padova, J.